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Vol. XI BALTIMORE, MD., MAY 15, 1915 No. 3

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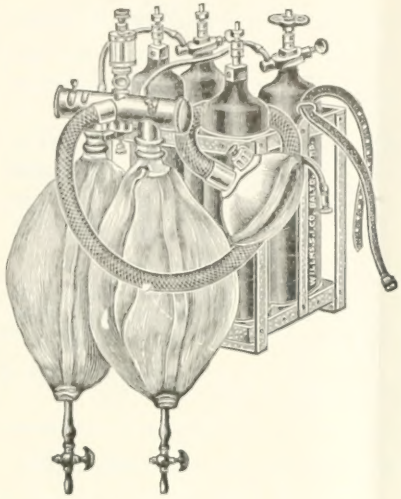

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OF THE UNIVERSITY OF MARYLAND

MAY 15, 1915

CONTENTS

ORIGINAL ARTICLES—

The Removal of an Open Safety-Pin from a Left Terminal Bronchus. Richard H. Johnston, M.D. 37

Surgical Physiology of the Circulation and Respiration. M. J. Egan, Jr. 39

Tonsillectomy During Acute Endocarditis. W. H. Harrison, M.D. 41

Sprue or Chronic Diarrhea of the Hot Countries. A. K. Moilliet, M.D. 46

EDITORIALS 48

The 117th Annual Meeting of the Medical and Chirurgical Faculty of Maryland.

State Board of Statistics for 1914.

ITEMS 48

MARRIAGES 53

DEATHS 53

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THE REMOVAL OF AN OPEN SAFETY-PIN FROM A LEFT TERMINAL BRONCHUS.

By RICHARD H. JOHNSTON, M.D.,
Baltimore, Md.

In July, 1914, I was asked to see M. C., aged six years. Her history was that in September, 1913, hoarseness developed which the parents were unable to account for. The family physician could find no cause for the trouble, but, as the tonsils were diseased, thought that they might have something to do with the symptom. They were accordingly removed, with improvement in the general condition, but the hoarseness persisted. The little patient was referred to a specialist in March, 1914, who was unable to get a good view of the larynx with the mirror. From the history of the case he concluded that the patient was suffering with diffuse papillomata of the larynx. The case dragged on, with the result that in July I was called to the Maryland General Hospital to examine the child with the direct laryngoscope, since it was impossible to examine the larynx with the mirror. As I entered the operating-room the family physician told me that the father had just informed him that the patient had swallowed an open safety-pin in September, 1913, shortly before the hoarseness developed. She had had a severe coughing attack at the time, but had soon quieted down and since had had only the hoarseness. The child was pinned in a sheet so that arms and legs were immovable and placed on the table with the head straight and held by a nurse. No anesthetic was used. The small laryngoscope was passed, and when the larynx was exposed the safety-pin was seen lodged in the upper part of the trachea, open, with the pin up and sticking in the mucous membrane. Forceps were introduced through the tube and the pin seized, the object being to draw it into the lumen of the laryngoscope and by careful manipulation to withdraw pin, forcepts and tube together, as I had done in other cases. Unfortunately, the pin from its long sojourn in the body was encrusted with salts, and thereby weakened, so that when the attempt was made to remove it it snapped off and the body disappeared. About one-third of the pin came out with the forceps. The next day an X-ray picture was taken and the pin was seen in the left main bronchus, with the clamp in and the pin out, apparently sticking in the mucous membrane. The next day the 5 mm. bronchoscope was passed under chloroform anesthesia. Though atropin had been given, the mucous secretion was excessive. After much mopping the clasp of the pin came into view. When forceps were introduced to grasp it a sudden paroxysm of coughing displaced it and the most careful search failed to find it. As the patient had been under anesthesia some time, it was decided to wait a week before making another attempt at removal. A second X-ray picture showed the pin further down in the bronchus. At the second attempt the patient took the anesthetic badly, so that, though the pin was seen, the bronchoscope had to be hastily withdrawn. Because of the great quantity of secretion at previous attempts and trouble with the anesthetic, it was thought best to do a tracheotomy and to try to remove the pin through the wound. This was accordingly done, but no attempt at removal was made at this operation. The patient was allowed to rest a week, and another X-ray picture made, which showed that the pin was steadily traveling downward. When preparations were made for

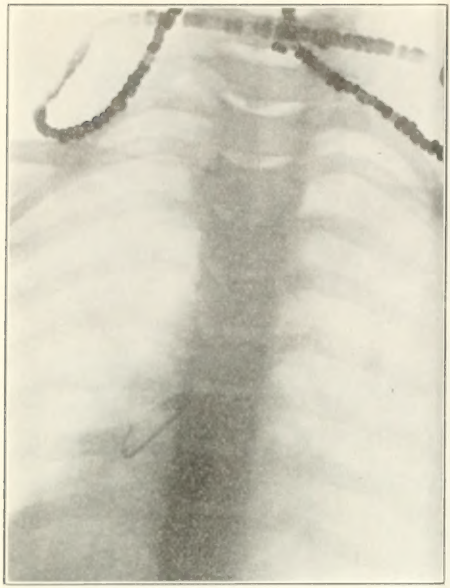

FIG. I.—First resting place of pin.

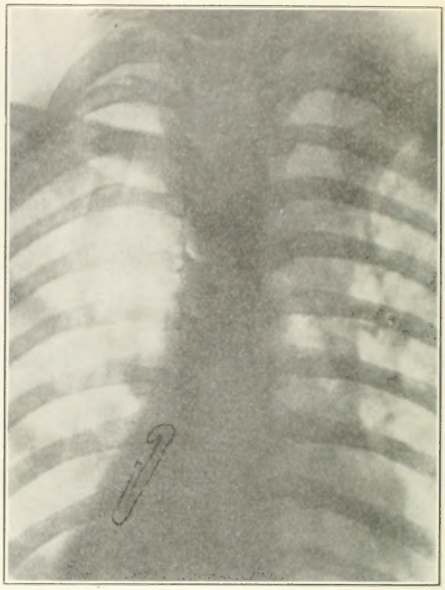

FIG. III.—View of pin in terminal bronchus.

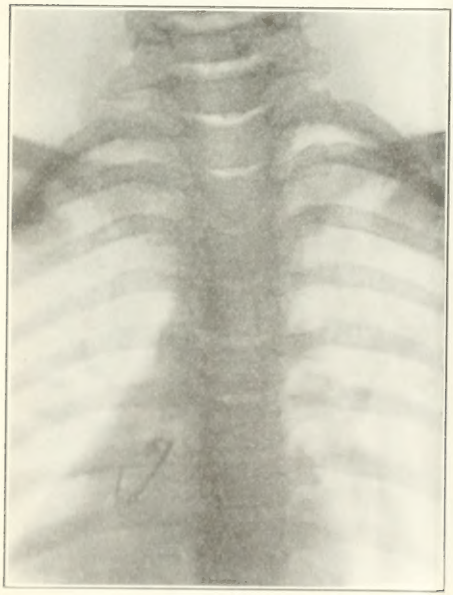

FIG. II.—Second resting place of pin.

FIG. IV.—View of pin taken from side.

what was hoped would be the final operation the pin lay between the eighth and tenth interspaces on the left side near the midline, with the pin behind. It had thus turned 90 degrees in passing from the main to the terminal bronchus. At the last operation just enough chloroform was administered through the tracheotomy wound to keep the patient reasonably quiet. Jackson's 5 mm. tracheoscope was passed through the wound and pushed rapidly down into the left bronchus until the terminal bronchi were seen. At first the pin did not come into view. Careful examination revealed a closed terminal bronchus near the midline, caused by swelling of the mucous membrane. Attention was directed to this bronchus. A sudden cough opened it up and revealed the clasp of the pin. Jackson's forceps were passed through the tube, the bronchus carefully dilated, the pin seized, and pin, forceps and tube withdrawn. The pin was deposited on a table, and when it was picked up a moment later it broke off at the coil. The little patient made a good recovery. The successive steps of the pin's travels are shown by the X-ray pictures. In the first picture the pin is seen in the seventh space; in the second it has passed down to the eighth space; in the third it has reached its final resting place in the ninth space in the terminal bronchus. That it would have worked its way still farther down, where it would probably have been impossible of removal, is certain. The death of the patient would have followed.

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SURGICAL PHYSIOLOGY OF THE CIRCULATION AND RESPIRATION.*

By M. J. Egan, Jr., Class of '15.

The heart muscle, the most important functional muscle of the body, possesses many characteristics which, from a surgical standpoint, are of great importance.

In the first place, it shows notable differences in its response to trauma of various kinds, as direct manipulation of the organ in one individual may have but slight effect, whereas in another it may cause irregularity and even inhibition. The direct trauma of the heart in the solar plexus blow may not be serious, and again it may cause death by mechanical inhibition, not reflex inhibition. No drug will protect the heart against such alterations due to mechanical manipulation or trauma, not even anesthetics, and hence the importance of prevention of these things or in minimizing them as far as possible in operations on and about the heart.

Now, a heart the muscle of which is damaged by acute or chronic diseases, age, etc., is naturally more susceptible to alteration as result of trauma, and therefore the better surgical risk of the young adult heart.

While at this point it may be well to mention something of the difference in the gravity of a collapse due to reflex inhibition of the heart by an electric current and the inhibition that results from the passage of the current directly through the heart muscle. In that due to the former resuscitation may be accomplished by prompt rhythm pressure upon the thorax over the heart, which produces artificial circulation and respiration; in that due to the latter, however, resuscitation is impossible.

As far as the heart itself is concerned in general surgical practice there are two things which demand special attention, viz., acute dilitation and paralysis. Before touching briefly on these two things, there are two important facts which must be borne in mind:

1st. That the work done by the heart is in geometric ratio to the blood pressure in the large various trunks, and hence the amount of blood entering it, i. e., if twice as much blood enters the heart it has four times as much work to do, and so on.

2d. That the heart is functionally impaired immediately on diminution of the coronary blood supply to its own muscle.

Application of these principles.

1st. Take a case where the intrapulmonary pressure is rapidly increased, giving the heart no time to compensate, as in positive ventilation of the lung by artificial respiration with a pulmotor. There is caused a rapid accumulation of venous blood on the right side of the heart, with the enormously increased work, and an inability to empty itself efficiently, and in addition a lowered nutrition of the heart muscle. The result may be a fatal paralysis or acute dilitation.

2d. Take a case of acute hemorrhage, where, in addition to the diminished flow of blood through the systemic arteries there is a diminished flow through the coronaries, thereby impairing the

*Presented before the Randolph Winslow Surgical Society.

function of the heart muscle. Now, suppose that with the heart in this state we would suddenly increase its work by a rapid intravenous infusion, we would naturally see that in the presence of weakness the heart is liable to an acute dilitation or paralysis causing death.

The anesthetic itself may impair the heart to such an extent as to lead to acute dilitation, recognized by the extensive venous congestion, lividity and collapse of the pulse. Treatment of such cardiac collapse is—

1st. Remove the cause.

2d. Venesection may give immediate relief.

3d. Place patient in an inclined position, with foot down, so the blood will gravitate below the diaphragm.

4th. After this is all done, give cardiac massage by rhythmic pressure over the thorax and maintain artificial respiration.

It will be seen the importance of promptly differentiating between the collapse due to cerebral anemia and that due to cardiac dilitation as the best treatment for the former (inclined position, with head down) is the worst treatment for the latter.

From what has been said it will be seen that in every operation and anesthesia it is very essential that we take as accurate stock as possible of the cardiac reserve force (disease and senility being especially considered), so we can so control any operative effort that it will fall within the margin of safety. This margin may be considerably widened by a preliminary treatment with digitalis or strophanthus.

When any operation is directed toward the heart itself, approach it slowly and gradually, allowing it time to recover from slight manipulation, and in this way it will usually tolerate much trauma, remembering always that the heart is [illegible] to any [illegible] sudden change in blood pressure and sudden application of trauma or mechanical manipulation. So much for the heart.

[illegible] consideration of the vasomotor system, chiefly as to its influence of general surgery on the physiology of the circulation is concerned, [illegible] more attention than the heart, for the causes of surgical death arise far more frequently from this than from the heart.

The blood pressure is mainly controlled by the vasomotor center [illegible] peripheral vessels, and when this tonic control is interfered with, as in paralysis or depression from operative or accidental trauma, from toxins of infection, from lowered blood pressure in hemorrhage, etc., we have the condition known as surgical shock.

It is the vasomotor center that regulates the compensating [illegible] phenomena of the increasing of the blood pressure in one place to counterbalance a lowering in another, e. g., the interrelation between the splanchnic area and the brain, as when intracranial tension is increased by a hemorrhage, abscess, etc., threatening an anemia of the vasomotor center, impulses are sent from this center to the splanchnic area, causing constriction here and rise of blood pressure, thus reestablishing the circulation required for this and other centers in order that they may continue their normal functions.

This center is also affected in the acute infectious diseases, and in those which interest the surgeon most (pyogenic infections) the blood pressure is raised in the beginning, because the vasomotor center is stimulated. Typhoid toxins depress the center, and in typhoid we have an opportunity at times to witness a combination of the two actions, e. g., when perforation takes place, introducing a pyogenic infection, there is sometimes early an increase in the blood pressure.

Now we go on to another important phase of surgical physiology, that of respiration.

The diaphragm is the most important and the only typical muscle of respiration, the accessory muscles having other functions to perform.

If the respiratory center is being gradually overcome by an anesthetic, the muscles of the neck and shoulder, being more voluntary, are affected first; then the abdominal muscles, and finally the diaphragm. Therefore, paralysis of the accessory muscles is a sign of excessive anesthesia which must be heeded.

Operations in certain regions modify the respiration, as the noisy inspiration caused by stretching the sphincter ani, by contact with the scrotum and rectum in operations on the pelvis, also the noisy expiration often seen in operations in upper part of the abdomen. Contact with the peritoneum may cause an expirator phase so severe as to amount to an expulsive action causing protrusion of the intestines through the wound. The more force exerted in endeavoring to replace these intestines the greater the expiratory expulsive action, whereas if they are handled gently,

they will be correspondingly more easily replaced into the abdominal cavity.

Manipulation of nerve trunks in most parts causes increased respiratory action. Respiratory inhibitions may also occur, e. g., in those areas supplied by the laryngeal nerves. Too great traction on the tongue, swabbing out of the pharynx, pressure on the larynx or even gentle manipulation of the laryngeal mucosa may cause temporary inhibition of the respiration or heart.

In those conditions where the accessory respiratory muscles are necessary for maintaining respiration and life anesthesia is absolutely contraindicated, because these muscles, being voluntary, are just as easily paralyzed by the anesthetic as the other voluntary muscles of the body, and would lead to immediate death.

Also the respiratory center is easily paralyzed when it is subject to increased pressure, and hence we have to be extremely careful when operating on the skull for hemorrhage, abscess, etc., and often have to use local anesthesia until the cranium is opened and the pressure relieved, when general anesthesia may then be begun with comparative safety.

Two other things of (importance) interest physiologically are the diaphragm inhibition in gallstone colic and the increased respiratory movement in peritonitis. The first is explained by the fact that the afferent nerves of the gall bladder carry their impulses to the segment of the cord adjoining the phrenics, transferring them to the phrenics. The second phenomena is due to the inhibition of the abdominal respiratory muscles, thus diminishing the excursion of the diaphragm and lower ribs, which, in turn, diminishes the area of functioning lung.

Now, in conclusion, it may be well to know that it is easier to re-establish the rhythmic action of the heart than to resuscitate the vasomotor or respiratory centers, and that the respiratory can be revived more easily than the vasomotor.

The heart itself has been resuscitated at long periods after it has ceased beating, and this is accomplished only when oxygenated blood is circulated through the coronary vessels at a pressure of 30 mm. of Hg. or more.

Therefore, the first thing to be done is to establish such a circulation through the coronary vessels, which is accomplished in the following manner:

Intravenous infusion.

Massage of heart over thorax. These two things alone would not be effective, because the vascular tone is lost and the periphery relaxed, thereby making it very difficult to establish the required blood pressure. As the peripheral resistance is lacking, we should endeavor to raise it. This is done by administration of adrenalin, preferably in the infusion, so that it will be uniformly and more rapidly distributed throughout the body. There is an increase in peripheral resistance producing increase in blood pressure, and in none of the arteries more so than the coronary. When the 30 mm. is reached the heart begins rhythmic contractions. Massage favors the circulation up to this point, but should now be withheld, and the circulation favored by gravity, by placing patient in head-down position and bandaging the lower extremities and abdomen. When the vasomotor center has received a sufficient circulation under a given pressure it will resume its normal action, and about this time the respiratory center begins to act, shown by faint inspiratory action, gradually increasing in strength until the normal respiratory rhythm appears.

During this process of resuscitation we must keep a careful watch on the cardiac action, as the weakened muscle may not be able to cope with the sudden increase in the blood pressure and signs of acute dilitation or paralysis may ensue, when we would have to inaugurate the treatment heretofore described.

TONSILLECTOMY DURING ACUTE ENDOCARDITIS.*†

By W. G. Harrison, M.D., Class of 1892, Birmingham, Ala.

In 1900 Dr. Abraham of New York presented to the Alabama State Medical Association a most interesting paper entitled, "Acute Tonsillar Diseases and Their Sequelae." He mentions that in 1866 Trousseau was the first to suggest the casual relationship of acute tonsillitis to rheumatic fever. He refers to the *British Medical Journal*, 1906, where Wade reports several cases of rheumatism following the first attack of tonsillitis, and also states that Wagner in 1895 reports two cases in which the same organism found in the diseased

*Read before the Jefferson County (Alabama) Medical Society, March 16, 1911.

†Reprinted from the *Southern Medical Journal*, January, 1911.

[illegible] subsequent to the literature quoted in Abrahams' [illegible] various other authors have made exhaustive [illegible] of the relationship between tonsillar [illegible] and acute rheumatic fever.

In *Medical News*, page 44, of June, 1887, Haig-[illegible] (Tonsilitis Adolescentium) reports 345 [illegible] of tonsillitis, in 43 of which a cardiac murmur developed, 8 cases terminating in chronic [illegible]. Ten had physical signs of mitral regurgitation, which disappeared. In the article on [illegible] endocarditis in *Modern Medicine*, Vol. 4, page [illegible], he says that the tonsils are probably the portals of entry for the micro-organisms of the not infrequent cases of endocarditis without recognizable cause.

In 1899 Wassermann and associates experimented with germs removed from a fatal case of rheumatism and produced arthritis with characteristic rheumatic lesions in over 80 rabbits.

In 1900, Paine and Poynton, of England, first published a thorough study on eight or ten cases of acute rheumatism, from which they isolated their "diplococcus rheumaticus," which produced the characteristic changes of rheumatism in the joints of various animals.

Meyer and Davis of Chicago examined the diseased tonsils removed from 45 patients, and in nearly every instance found streptococci in the crypt debris. He studied the virulence of these organisms by injection into rabbits. Arthritis developed in all cases, and in several there were definite heart lesions. In the *Journal of Infectious Diseases*, Vol. 10, page 148, last year Davis reports a bacteriological examination of extirpated tonsils of [illegible] cases, and mentions that the tonsils were removed from cases of joint disease, heart disease and nephritis. Under the head of other results he says:

"There were records of endocarditis, nearly all of which were either suffering from arthritis or gave a history of having had it in the past. They were not, as a rule, severe, except in two, which were malignant in character. Hemolytic streptococci were found in the cases and predominated. In the remaining cases were large numbers of streptococci and in two cases these streptococci were nearly pure. In one case of fatal malignant endocarditis, with pneumonia in the throat and in the pleural and pericardial sacs, the tonsils were only slightly enlarged but were deeply [illegible] with fibrinous exudate from the surface, and some of patients with rheumatism [illegible] subsequent to the literature quoted in Abrahams' [illegible] various other authors have made exhaustive [illegible] of the relationship between tonsillar [illegible] and acute rheumatic fever.

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Rosenow, by blood culture, isolated an organism which he believed to be a modified pneumococcus, and by intravenous injection he was able to produce endocarditis in a number of animals. The organism described by Rosenow has all the characteristics of the [illegible] organism isolated by Davis from tonsillar disease. Davis, after elaborating his experimental work, states that perhaps the therapeutic results of tonsillectomy furnish the best argument we have so far in favor of the idea that infected tonsils bear some casual relationship to arthritis, renal and cardiac conditions.

Some years ago Gurich of Munich reported in the *Münchener Medicinische Wochenschrift* 125 cases of rheumatism treated by tonsillectomy, with great benefit to 98 cases. He was unable to follow 15 out of the other 27. One of his collaborers reported a careful review of 70 cases of acute rheumatism where the tonsils were removed with marked improvement.

In 1908 Rosenheim, in the *Johns Hopkins Bulletin*, reviewed the literature and reported from the Johns Hopkins clinic a number of cases of rheumatic fever relieved by tonsillectomy.

Mitchell of Cincinnati, in the *Archives of Pediatrics*, Vol. 20, reports cases of tonsillitis followed by appendicitis, nephritis and acute endocarditis.

In the *American Journal of Medical Science*, 1909, Packard has reported five cases of endocarditis following attacks of tonsillitis.

Wiseman, in 1912, in the *New York State Medical Journal*, under "Cardiac Sequelae of Tonsillar Infection," mentions 25 cases of tonsillitis followed by cardiac lesions. In seven other cases slight cardiac disturbances were present. He reports a number of cases showing the improvement after tonsillectomy. Referring to one of these patients, he says:

"Here we have the picture of a slight throat inflammation, hardly severe enough to be dignified by the term tonsillitis, followed by signs of cardiac mischief and fever lasting many months. On the contrary, the second attack of tonsillitis, which was accompanied by severe symptoms and high temperature, seemed to have no deleterious effect upon the heart or other organs. It seems as if the fury of the infection has spent itself upon the tonsils, exciting a severe inflammatory reaction, which was sufficient to prevent the organisms from penetrating farther."

I must say that in [illegible] I agree with the

conclusions of many other observers with reference to the complications in general following tonsillitis. The worst cases of arthritis seem to follow the milder cases of tonsillar disease. In no case of a violent tonsillitis with temperature above 103½ have I noted any subsequent joint complications, though I have records of some 35 or 40 cases of joint or cardiac inflammation following the milder cases of tonsillitis.

Higgs, of Portland, Ore., writing in the *Northwest Medical Journal,* Vol. 3, page 316, on "The Relation Between Diseased Tonsils, Rheumatic Fever and Heart Disease," refers to the work of Rochinot of Munich, who reports an epidemic in a German hospital following the admission of a patient suffering with follicular tonsillitis. From this patient 17 others and a nurse developed tonsillitis. Of the 18 cases, three had acute nephritis, one endocarditis, one pericarditis, and one acute myocarditis.

From this very brief reference to the literature one is impressed that *mild tonsillitis* is a much more serious disease than is generally recognized. This is especially true with reference to cardiac complications. Kretz of Germany, Morse of Boston, Loeb of St. Louis, Todd of Minneapolis, Billings of Chicago, Thayer and Hunner of Baltimore, and others, have stressed its importance in extra cardiac conditions. About 1911 I first seriously debated the wisdom of tonsillectomy on a case of acute endocarditis. It seemed a serious departure from the usual custom, but I argued if the patient could survive the anesthetic and the operation, then his chances of recovery were largely augmented, as the tonsillectomy would remove the chief depot and incubator of his infection. During the past three years I have operated on six of these cases, which will now be reported. I quote largely from notes given by the physicans with whom I saw the cases in consultation. It might be mentioned that in each of the first four cases the tonsillar crypts were first carefully cleansed by daily syringing with a 10 to 50 per cent. solution of alcohol, in the effort to remove as far as possible the septic debris, thereby building up the patient's general vitality prior to the operation.

If one could empty every crypt this would afford temporary relief and assist in conserving nature's constructive forces, but unfortunately we cannot feel sure in any case of finding every focus of poison.

Case 1—C. D., w. m., age 14, first seen in March, 1911, has had repeated attacks of tonsillitis and arthritis, and a year ago was confined to bed for three months because of a bad heart. Seen in consultation with Dr. Ward, from whose notes this report is quoted.

"Physical examination: Frail, anemic boy, heart much enlarged. Loud systolic mummur over greater portion of chest. Pulse, 100-120; temperature, 100-102. Patient put to bed and large doses of salicylates administered." During this time the tonsil crypts were carefully treated and every effort made to put his throat in the best possible condition. To quote again from Dr. Ward's notes:

"He was kept in bed 2½ months with some improvement, occasional relapses associated with recurring mild attacks of tonsillitis. June 15 his tonsils were removed under ether anesthesia. There was a definite increase of the cardiac dilatation during the administration of anesthesia and performance of the operation. Following the operation there was immediate and rapid improvement. The enlarged heart gradually approached its normal condition and size. The pulse came down to 70 or 80, the murmur continuing. By October the patient was able to enter school, and in a few weeks was playing ball and appeared in splendid health. This improvement continued for two years, when he went down with a definite attack of rheumatism, and within a month his heart seemed to be in worse condition than ever. From November 13, 1913, to March 5, 1914, he had a stormy time, recurring attacks of arthritis and several strokes of apoplexy and probably emboli. There were aphasia and coma with the right-sided strokes. These attacks would completely clear up. The kidneys functionated perfectly during the entire time. Finally on March 5 there was a more violent stroke of apoplexy, and he died in coma."

I might mention that several years before I first saw this boy his tonsils had been cut off, but no effort had been made to remove them entirely. Had the complete operation of tonsillectomy been performed at that time possibly the patient would never have suffered such serious heart impairment. No reflection, however, is intended on the operator, because the complete operation of tonsillectomy had not been perfected, nor was it deemed desirable.

Case 2—M. H., white, age 14, consulted the February 29, 1912, for examination of eyes to relieve headache. He has been having rheumatism more or less for the past two years, and loses from two to three days from school each week because of joint pain and precordial discomfort. She has had several attacks of rheumatism since 1910, beginning with sciatica on the righ side lasting six weeks. For the past two months has been unable to use left hand much of the time. She has had four to five attacks of acute tonsillitis annually for the last three years. During these attacks the temperature rarely gets above 100½ or 101, and the throat is sore for about a week. Pain over the heart began July, 1911, and has been present since that time. Pain is aggravated by efforts to lift or carry any weight, and is particularly severe on going up stairs or walking rapidly. At this time there was no murmur. The P. M. I. just outside of the nipple line. The pulse 110-120, with temperature 99½. The patient was advised to remain in bed under supervision of her family physician, Dr. Rosemond, for a while. After the temperature had been normal for a week and the pulse below 100 she visited my office and I cleaned out the crypts as best I could. Her general condition improved somewhat, but about May 1 she had a return of fever, with increase of precordial pain. And on May 7 she entered a hospital and the tonsils were removed under anesthesia administered by Dr. Rosemond. The left tonsil was fairly clean, but there was a compound pocket of pus in the right that had been overlooked in the efforts to cleanse the tonsils by above-mentioned treatment. After a week she had no further return of fever, and has had no definite arthritis since the operation. She still has occasional muscular pain, and on exertion some precordial soreness. Her general health has improved in every way, and she has gained some 15 pounds, and she is able to attend school without loss of time.

Case 3—W. S., age 19, student, was first examined by me in May, 1912, beginning Dr. Pilcher's case. The patient's personal history is negative with the exception of an attack of typhoid fever eight years ago and frequent attacks of tonsillitis. He has always been athletically inclined, and for several years has taken part in baseball and track. The patient complains of a frequently recurring sharp pain in the precordium. At times there is a sensation of oppression accompanying this pain. At others he feels as though he was about to faint. Dyspnea and palpitation are easily excited by climbing stairs or walking up hill. There is occasional vertigo and frequent temporal headaches. The patient can give no exact date at which these symptoms first appeared, but it is quite certain the onset was very gradual, and started at least two years ago.

"Physical examination: The patient is a robust young adult, whose average weight is 175 pounds and height 5 feet 11½ inches. There has been a slight failing in his weight since the onset of the symptoms described above. Examination of the mouth revealed the presence of Riggs disease of the gums and chronically infected and enlarged tonsils. The vessels of the neck pulsated forcibly. The violent action of the heart was evident over the entire precordium. There was a marked systolic thrill just above the sternal end of the right clavicle. No other thrills present. The pulse was full and strong, and somewhat irregular. The heart was markedly enlarged, the apex being easily palpable in the sixth interspace just inside of anterior-axillary line. At the second right costal cartilage there was a soft, blowing, systolic murmur transmitted to the base of the heart. The second sound at this point was short and rough. Above the clavicle near the point where the thrill was palpable there was heard apparently the same systolic murmur which we have just described. At the fourth left costal cartilage there was a systolic murmur of the same character as that described above and a short, rough, diastolic murmur. At the apex in the sixth interspace there was a loud systolic murmur transmitted into the axilla. The blood pressure was 140 systolic and 85 diastolic. With the exception of a small mucous rale here and there the lungs were negative. The liver extended two fingers' breadth below the costal margin and was somewhat tender. The spleen was palpable. The temperature was normal, the hemoglobin 90 (Sahli), the white blood count 5700, the urine negative. The patient was put to bed and placed upon treatment commonly pursued in these cases. During this time he had an acute attack of tonsillitis, which excited a distinct increase in the severity of the heart symptoms. The throat was treated by local applications, and in a few days began to improve. From this time on he grew progressively better. In six weeks he was up and about again, feeling better than he had in many months. There was still an

occasional return of the pain in the precordium, although nothing like so severe as before. The dyspnea and palpitation were scarcely noticeable. While the throat exhibited no evidence of inflammation, every now and then he complained of a distinct sensation of soreness or dryness. Dr. Harrison was first asked to see him June 11, 1912. On his advice the tonsils were treated palliatively for some time and not removed until September, 1912. While up to the time the tonsils were removed the patient had been gaining steadily and the physical signs growing less well marked, the course of the symptoms after the tonsillectomy showed a more rapid improvement than before. The patient himself remarked on this, independent of my observation. At the present time the patient is doing light work around the office of a lumber camp. The precordial pain has entirely disappeared and palpitation and dyspnea are evident only when he forgets himself and either runs or does some heavy lifting. The last examination of the patient, made several months ago, showed the apex beat of the heart just outside of the nipple line and the force of the heart's action not materially increased. The thrill above the clavicle had disappeared, the systolic murmur at the second right costal cartilage could scarcely be heard, but the diastolic sound at this point was distinctly accentuated. Of the murmurs previously found at the base of the heart only the diastolic remained, and that not well marked. The systolic murmur originally heard at the apex was still to be found, but not so loud. The blood pressure was 135 systolic, hemoglobin 95 (Sahli)."

One may question whether this case should not properly be classed as chronic rather han acute endocarditis. I think Dr. Peters regarded it as a chronic endocarditis with frequent acute exacerbations during the last of which he underwent the operation.

Case 4—Quoting Dr. Lull: "Archie W., age 15, was seen by me December 18, 1912 in an acute attack of rheumatic fever which followed closely a mild attack of tonsillitis. On examination his throat and tonsils were slightly reddened, temperature 100, pulse 90. The original attack of tonsillitis was two weeks before. At this time, December 18, he was suffering with pains in various joints, but especially the wrists and ankles were swollen and feverish. There was already a slight mitral insufficiency. With absolute rest in bed and usual anti-rheumatics, aspirin, salicylates and alkalies, the arthritis improved somewhat, but the heart condition grew worse.

"January 2, 1913, two weeks later: The heart has continued moderately enlarged, with a loud, blowing, systolic murmur, and the patient suffers some from dyspnea even on turning or raising himself in bed. From this time on the patient was kept strictly quiet, having a nurse constantly caring for him. His general condition improved somewhat, but the heart enlargement and character of the murmur were unchanged at the time of operation, February 1, 1912."

I might say there was nothing unusual attending the operation. Because of the rapid heart action and precordial pain on movements in bed, we had felt some anxiety about the ether. Dr. Lull kept a stethoscope on the heart a part of the time, and noted no change in the murmur and but little acceleration of the rate. As in Case 1, there was a large pocket of pus or debris in one tonsil which we had overlooked or been unable to reach in the preoperative treatment.

After-history: "This boy's heart has shown marked improvement. Had a small, round-celled sarcoma of left humerus removed about six months ago. Took gas and oxygen. Present health is good, though tires easily from exertion. Has had no rheumatic trouble since his tonsillectomy."

Case 5—Quoting Dr. Lull: "J. W., w. m., age 25, was seen first June 21, 1913, giving a history of repeated attacks of tonsillitis followed by acute arthritis affecting the ankles and knees and wrists of both sides. The patient had improved somewhat while under treatment in the West, but two weeks before seemed to suffer a relapse and was then practically bedridden on account of the arthritis. Examination showed swelling and tenderness of both wrists and ankles. Temperature 100-101, pulse 80-90. The heart was slightly hypertrophied and showed a moderate grade of mitral regurgitation. The tonsils were enlarged, but not actually inflamed. Examination otherwise negative. Case referred to Dr. W. G. Harrison."

Party given gas followed by ether. Nothing unusual at time of operation except rather full venous oozing, patient losing one or two ounces of blood. Each tonsil showed a rather extensive cryptal retention of white cells and exfoliated epithelium—a veritable incubator for pathogenic bacteria.

March 10. "Marked improvement in general

condition. Patient married a few weeks later and was well and happy at last report." (Lull.)

Case (c) (quoting Dr. McLester): "On December 3 I was called to see Miss P., a nurse, who had a temperature of 103, tonsillitis, and indefinite pains in her joints. These symptoms subsided within a few days, and she was permitted to get out of bed. Five days later I again saw her, at which time she showed a marked arthritis in the right ankle, accompanied by considerable fever. After a few day's rest in bed the arthritis subsided. At this time a definite systolic murmur, heard best at the apex, appeared. During the next two weeks frequent exacerbations of the arthritis were seen, and she maintained a slight but constant elevation of temperature. It was deemed advisable to remove the tonsils, because evidently they were the source of the infection. After removal of the tonsils the arthritis and [illegible] disappeared.

"Prior to operation pulse was about 110-120, but increased above 170 at time of operation, and it remained fast and weak, though regular for a time. After about 10 days it got much stronger, and after three weeks the rate remained under 100. In this case the crypts had not been properly treated, and at time of operation they were much distended, with foul, cheesy debris."

From the literature above mentioned and the cases detailed it would seem the following conclusions are justified:

1. Rheumatism or acute rheumatic fever, with its frequent complications of endocarditis, pericarditis, chorea, etc., is often the result of acute cryptal tonsillitis.

2. The milder attacks of tonsillitis with lower temperature and transient sore throat are more apt to be followed by the arthritis than are the severer attacks of tonsillitis.

3. It is often wise to perform tonsillectomy during an acute attack of endocarditis and remove the source of infection than delay with the hope of operating after the acute attack has subsided.

4. Once or twice may cleanse the tonsil crypts by local applications and syringing with antiseptic solutions, but in one of the more virulent cases it will sometimes be impossible to find even [illegible].

5. Operation of Choice. The writer believes that cultures should be made from the tonsil in all cases of [illegible] involvement and properly preserved, from which vaccines could be made and the patient properly treated with these in cases where the fever and other signs of infection do not disappear within a reasonable time after the operation.

SPRUE OR CHRONIC DIARRHEA OF THE HOT COUNTRIES

By A. E. Abercrombie, M.D., B.M.C.,
Class of 1903.

Having read with much interest in the February number of this journal the report of the fatal case of diarrhea by Dr. Craige, it may not be out of place to describe some of the features of the obscure form of ulcerative enterocolitis known as sprue.

While this disease has, I believe, only been reported from India, Ceylon, China, Japan and the West Indies, it is highly probable that it is much more widely spread in the New World. Chronic diarrhea of the same character is common in Central America and Southern Mexico. I remember, about six months ago in the Charity Hospital of New Orleans, Dr. Custis pointing out the similarities of a case he had in his ward with sprue and making a provisional diagnosis of this disease.

The following are perhaps the chief characteristics:

(1) No specific agent constant, though various organisms, including the ameba coli, have been incriminated.

(2) Insidious onset, with dyspeptic symptoms, very gradually becoming worse, distention of abdomen after meals, belching, with occasional nausea and vomiting.

(3) Stools soft, abundant and bilious, becoming later on frothy and lienteric, without containing blood, occurring especially in the early morning (Sulle cronille Mattutine d'Oriente). Their passage is accompanied with a sense of relief, there being no tenesmus nor pain.

(4) Atrophy of the liver often not marked.

(5) Tongue at first moist and coated, soon stained with a brown tint in the middle. Later on pain is felt and small, slightly raised red spots appear at first round the edge and at the point of the tongue, which later become confluent. Ulcers often form near the last molar teeth (Cromlie's ulcers). Speech and deglutition become painful

and difficult, the urine diminishes, profound anemia, with earthy-colored facies, and melancholia appears, and the patient ultimately dies from cachecia or some other intercurrent disease, notably tuberculosis.

A remarkable feature is the periodic improvement, with or without treatment. Sometimes constipation lasting for weeks may appear, but usually the stools during the periods of temporary improvement are still somewhat lienteric. (Jeauseline and Rist.)

It is curious to note that in some countries, such as the Malay Archipelago, the mouth symptoms predominate (Thin), while in others, as the West Indies, diarrhea is the only symptom for years, and the aphtha only appear toward the end of the disease (Manson).

Here on the Isthmus of Tehuantepec lienteric diarrhea is often associated with the presence of trichocephalus. Not infrequently we can find no cause for it after a most thorough examination of the stools. In the hill country of Puebla, in Southern Mexico, lienteric diarrhea is extremely common, and in my experience frequently fatal.

The diagnostic points between sprue and dysentery are briefly as follows:

Sprue.	*Amebic Dysentery.*
Longer duration.	Less so.
Ameba absent.	Ameba present.
Stools in early morning especially.	Any time.
Frothy lienteric.	Slimy.
Without blood.	With blood.
Accompanied by sense of relief.	With tenesmus.
Mouth and tongue affected.	Not necessarily.
No pain or palpitation of abdomen.	Pain over colon.
No fever.	Slight.
No hepatic abscess.	Tendency to liver abscess.

In conclusion, I feel I should apologize for taking up so much space in describing a disease as well known as sprue, but it occurred to me as being the possible explanation of some of the obscurer forms of chronic diarrhea in the Southern United States.

Minatitlan, Vera Cruz.

Dr. Bernard Levinson, class of 1908, who is located at 116 Grand street, Newburgh, N. Y., writes us as follows:

"April 28, 1915.

"Editor Hospital Bulletin:

"Dear Doctor—Upon close scrutiny of the State Board number of the *Journal of the A. M. A.* I am pleased to learn of the excellent showing Old Maryland has made at the various examinations. My heart swells with pride to see the University of Maryland rank high in class 'A.'

"To the prospective medical student, however, a drawback confronts him in the form of non-recognition by several of the States—at a critical time, when his life's work fairly hangs in the balance. To avoid such pitfalls, I sincerely hope (and I know I voice the sentiment of many an alumnus) the University of Maryland raises its requirements to conform to the higher standards of today, so that no graduate be barred from any licensing examination, be it North, South, East or West. May that day arrive soon!

"I am enclosing a check covering subscription to THE BULLETIN.

"As you will note from the above, I have moved from Jersey to Newburgh, N. Y. I have taken over the practice of a retiring physician who has been here many years. Send all communications to the above address.

"With due respects, I am

"BERNARD LEVINSON, M.D."
"Class of 1908."

Dr. Levinson was formerly at 612 W. Front street, Plainfield, N. J.

Dr. Clifford T. W. Sappington, class of 1903, who was commissioned four years ago by President Taft as first lieutenant in the Medical Reserve Corps, United States Army, has been called to active service by Surgeon-General William C. Gorgas. Dr. Sappington has been in practice at Frederick, Md., and is a member of the County Medical Society. He left recently for Galveston, Tex., where he will be stationed.

Dr. Gordon Wilson, professor of medicine at the University, and Mrs. Wilson, who have been spending some time in the far South, have returned to their home.

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Editor . . . . . NOBLE WILLIAMS, M.D.

BALTIMORE, MAY 15, 1915

THE 117TH ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

The annual meeting of the State Faculty was held at the Faculty Building on April 27, 28 and 29, 1915, under the presidency of Dr. J. W. Humrichouse of Hagerstown, class of 1873. Dr. Humrichouse's address was retrospective in character, and told of the achievements of the Faculty and of the constructive work done for the public and for the profession. A very pleasant incident of the meeting was the presentation of a splendid portrait of the late Prof. William Travis Howard, M.D., LL.D., to the Faculty by his widow. The portrait is by Corner, the distinguished artist of this city, and is a life-size and life-like reproduction of Dr. Howard. He is depicted sitting in an easy chair, with an intent look upon his face, and one can easily imagine that he is saying, "Gentlemen, what we want is facts; bald-headed, bare-faced facts."

Instructive addresses were made by Dr. R. W. Lovett of Boston on "Infantile Paralysis"; "The Treatment of Pollinosis, or Hay-fever," by Dr. [illegible] New York, and "Marine Hospital Methods of Stamping Out Disease," by Dr. J. J. Lumsden of the Public Health Service.

The teachers and graduates of the University of Maryland took an active part in the scientific [illegible] several papers giving the results of original investigations were read, notably one by Dr. A. F. Voshell on "Blood Urea in Renal Disease," based on an extensive amount of laboratory work done in the University Hospital, and one by Prof. [illegible] on the "Treatment of Diffuse Heart Muscle Disease," in which he claims immediate and permanent reduction in the size of dilated hearts by the application of electrical current. Dr. Albert H. Carroll detailed his experiences in fractional gastric analysis in gall-stone disease. Other excellent papers were by Dr. E. H. Kloman, on Cesarean section; Dr. R. P. Bay, on thyroid surgery; recent experiences in spinal surgery, by Prof. R. Tunstall Taylor; obstruction of the choanae, by Prof. John R. Winslow, and some foreign body cases of the bronchi, removed by means of bronchoscopy, by Dr. R. H. Johnston.

The last evening was devoted to social entertaining of the country members and their wives, and was a great success. Dancing was indulged in until a late hour, and it was felt that a pleasant and beneficial innovation had been made.

The incoming president is Dr. John Whitridge Williams, class of 1888, professor of obstetrics at Johns Hopkins Medical School.

STATE BOARD STATISTICS FOR 1914

The results of the State Board examinations for 1914 have just been published in the report of the Council on Medical Education of the A. M. A. The record of the University of Maryland for the year is very gratifying to the teachers and alumni of the Medical School. One hundred and four graduates of all years took examinations, of whom 96 passed and 8 failed—7.7 per cent. These were examined in 21 different States, the percentage of failures in Maryland being 10.4, and of a larger number of candidates in the other States, only 4.1 per cent. failed; hence it cannot be said that we were favored by our own board. The graduates of 1910-14 who took examinations were 97, of whom 90 passed and 7 failed—7.2 per cent. Of the class of 1914 there were 81, of whom 77 passed and 4 failed—4.9 per cent.

While these results are gratifying, we cannot afford to relax our efforts, and we must strive to excel even this good record.

ITEMS

Today is the day of progressiveness at the University of Maryland. Hardly a day goes by without some manifestation of the passing of the old day of inertia. It is therefore with great pleasure that THE BULLETIN announces that the class of 1915, at a meeting of the local members, held March 8, 1915, in the office of Dr. Robert P. Bay, definitely decided to hold a decennial re-

union from June 22 to 24, inclusive. It is such events as these which mark the new spirit permeating the University of Maryland, and THE BULLETIN voices the sentiment that each and every class which has left or will leave its portals should do likewise. Certainly it should be a pleasure to old classmates after a period of labor and competition with the world to come back to their Alma Mater and relate how the world has treated them.

Nothing can add more incentive to better efforts than talks with one's classmates. Surely you, Arthur Bascom Croom, will be glad to see and talk with your old roommate, and so will you, John Martin Elderice, and you, John Shaw Gibson, and all the rest of you. Perhaps it will be news to some of you that Julius Levin and George William Mahle are dead. Therefore, THE BULLETIN urges that every one of the class return to the reunion, so as to make it a perfect success. Remember, your presence is absolutely desired. According to the tentative program, which appears below, every minute will be devoted to profit. There will be dinners, theater parties, clinics, etc. The election of Dr. Robert L. Mitchell (president of the class) as chairman, and Dr. Robert P. Bay, secretary, assures the success of the celebration. So do not mar it one bit by your absence. The program has been outlined as follows: Clinics, smoker, dinner at the Country Club and an afternoon at one of the shore resorts. THE BULLETIN heartily endorses the reunion, and sincerely trusts that each member of the class of 1905 will make it a point to attend.

The following is a list of those who have so far expressed their intention of being present:

E. H. Adkins, Roanoke Rapids, N. C.
C. M. Benner, Taneytown, M.
James S. Billingslea, Armiger, Md.
Ira Burns, Wilmington, Del.
J. J. Carroll, 185 Chestnut street, Holyoke, Massachusetts.
J. E. Dwyer, Venango, Polk county, Pennsylvania.
J. N. Elderdice, Salisbury, Md.
J. S. Gibson, Gibson, N. C.
M. R. Gibson, Raleigh, N. C.
G. B. Harrison, Colonial Beach, Va.
H. C. Irvin, Roanoke Rapids, N. C.
H. E. Jenkins, U. S. Naval Station, Port Royal, South Carolina.
H. L. Kneisley, Hagerstown, Md.
Eugene Kerr, Towson, Md.
J. P. McGuire, Clarksburg, Va.
J. S. Matthews, Spokane, Wash.
J. P. Matheson, Charlotte, N. C.
W. J. Riddick, U. S. Naval Hospital, Norfolk, Virginia.
J. L. Riley, Snow Hill, Md.
J. Holmes Smith, Jr., 163 Dryades street, New Orleans, La.
W. H. Smithson, New Park, Pa.
E. McQueen Salley, Saluda, N. C.
W. E. E. Tyson, Jefferson avenue E., Detroit, Michigan.
W. B. Warthen, Davisboro, Ga.

Appended is a list of the class of 1905, with their addresses, so far as we are able to ascertain:

Elmer Hall Adkins, Roanoke Rapids, N. C.
Julian Warrington Ashby, Hugheston, W. Va.
Samuel Luther Bare, Westminster, Md.
Robert Parke Bay, The Walbert, Baltimore, Maryland.
Chandos M. Benner, Taneytown, Md.
James Snow Billingslea, Armiger, Md.
Alvah Parrish Bohannon. (Unable to locate; in the State of Virginia; not in practice.)
Baird U. Brooks, West Durham, N. C.
Frank Burden, Paw Paw, W. Va.
Ira Burns, Relief Department, Pennsylvania Railroad Co., Wilmington, Del.
Roscoe C. Carnall, Waverly Mills, S. C.
John Joseph Carroll, 185 Chestnut street, Holyoke, Mass.
Edward Lawrence Casey, Woodstock, N. H.
Sydenham Lawrence Clarke, 423 Hawthorn road, Roland Park, Md.
Edward V. Copeland, Round Hill, Va.
Arthur Bascom Croom, Maxton, N. C.
Charles Callery Croushore, 108 W. 2d street, Greensburg, Pa.
Frederick De Sales Chappelier, Lewes, Del.
Seth De Blois, Newport, R. I.
David Alphonse De Vanny, 132 E. 61st street, New York, N. Y.
Alpheus Wood Disosway, Plymouth, N. H.
Manuel Dueno, Anasco, Mayaguez, Porto Rico.
James Eugene Dwyer, Venango, Polk county, Pennsylvania.
John Martin Elderdice, Salisbury, Md.
Oliver Justin Ellis, South Royalton, Vt.
Harry Moore Felton, 109 Climax street, Pittsburgh, Pa.

[illegible] Edgar [illegible], Hemphill, W. Va.
William Henry Fisher, Centerville, Md.
John Shaw Gibson, Gibson, N. C.
Milton R. Gibson, Raleigh, N. C.
[illegible] Goldsborough, 1917 E. [illegible] street, Baltimore, Md.
[illegible] W. Gwaltney, Lumberton, N. C.
Archibald Wright Graham, Chisholm, Minn.
William W. Hala, New York, N. Y.
Samuel William Hammond, Lambert's Point, Norfolk, Va.
[illegible] Blight Harrison, Colonial Beach, Va.
Henry Hiram Hodgin, Red Springs, N. C.
Henry C. Houck, 1914 Pennsylvania avenue, Baltimore, Md.
Hanner Carson Irvin, Jr., Roanoke Rapids, North Carolina.
Brooke I. Jamison, Jr., Emmitsburg, Md.
Francis White Janney, Wentworth Apartments, Baltimore, Md.
Harry Aquilla Jenkins, Assistant Surgeon, U. S. N., Port Royal, S. C.
Oswald Ottmar Kafer, Newbern, N. C.
Nagib Kenawy, 11 Boulevard de Ramleh, Alexandria, Egypt.
Eugene Kerr, Towson, Md.
Herbert L. Kneisley, Hagerstown, Md.
William A. Knell, Augusta avenue and Frederick road, Irvington, Md.
Kalil Magib Koury. (Address unknown.)
[illegible] Edgar Brown Le Fevre, Inwood, W. Va.
Julius Levin. (Died in Johnstown, Pa., [illegible], 1912.)
[illegible] William Mahle. (Died in Baltimore, Md., February 20, 1911.)
James P. Matheson, Charlotte, N. C.
[illegible] C. Matthews, Paulsen Building, Spokane, Wash.
[illegible] Skinner McCarty, Sandersville, Ga.
Harry Downman McCarty, 37 W. Preston street, Baltimore, Md.
John P. McGuire, Clarksburg, W. Va.
William Cuthbert McGuire, Huntington, W. Va.
[illegible] Cowling Metz, [illegible] W. North avenue, Baltimore, Md.
[illegible] Edgar Miller, [illegible] Maple street, Hinsdale, Mass.
[illegible] Louis Mitchell, [illegible] Maryland avenue, Baltimore, Md.
William Morris Mitchell, 80 [illegible] street, Bradford, Pa.
John Albert Nice, Mt. Airy, Md.
[illegible] Owens, Manchester, Va.
John W. Parker, Jr., Williamston, S. C.
W. Arlett Parvis, Acting Assistant Surgeon, U. S. A.; at present at Socorro, N. M.
John William Pierson, 2808 E. [illegible] street, Baltimore, Md.
Daniel E. Remsburg, Cresson, Pa.
Samuel T. R. Revell, Louisville, Ga.
William James Riddick, Assistant Surgeon, U. S. N.; U. S. Naval Hospital, Norfolk, Va.
William Wordsworth Riha, Bayonne, N. J.
John L. Riley, Snow Hill, Md.
John Edgar Brooks, Haughton, La.
Anton George Rytina, 2008 Madison avenue, Baltimore, Md.
Edgar McQueen Salley, Saluda, N. C.
Albert Leigh Sanders, 3015 Westwood avenue, Baltimore, Md.
Stuart Baskin Sherard, Gaffney, S. C.
John Holmes Smith, Jr., U. S. Public Health Service, 163 Dryades street, New Orleans, La.
W. Henry Smithson, Jr., New Park, Pa.
James Albert Stone, Charlotte, N. C.
Benjamin Franklin Tefft, Jr., Anthony, R. I.
William E. Ellicott Tyson, 2609 E. Jefferson street, Detroit, Mich.
Frederick J. Wass, 136 E. Duvall street, Jacksonville, Fla.
William Benjamin Warthen, Davisdale, Va.

Miss Augusta C. Russell, University Hospital Training School for Nurses, class of 1908, who has been located at 233 W. 4th street, Jacksonville, Fla., is spending some time at her home in Darlington, Md., where she will remain until the early fall.

Dr. Edward Barney Smith, class of 1907, is located at Criglersville, Madison county, Virginia. He was formerly at Meyer's Cave, Va.

At the last meeting of the Section of Ophthalmology and Otology, Baltimore City Medical Society, Dr. Edward A. Looper, class of 1912, of 37 W. Preston street, was elected secretary.

State Health Officer Dr. [illegible] Gilbert and his staff are busy with arrangements for the thoroughgoing sanitary survey of Anne Arundel county. The survey will require several months' work by a corps of experts, and will be done

jointly by the Federal Bureau of Health and by the State Board of Health.

The Federal Bureau will probably send over six of its experts to assist in the work.

Dr. Lewis M. Allen, class of 1896, who has been located at Winchester, Va., has moved to Gaylord, Va.

Dr. James A. Hughes, class of 1909, has moved to Mt. Carmel, Pa. He was formerly located at Strong, Pa.

Dr. Josiah S. Bowen, class of 1903, of Mt. Washington, Md., has been made a member of the "Clean Up and Keep Clean" Committee of Mt. Washington.

At a meeting of the Medical and Chirurgical Faculty of Maryland, held April 29, 1915, in the Faculty Building, 1211 Cathedral street, Dr. John Whitridge Williams, class of 1888, of 1128 Cathedral street, was elected president for the ensuing year to succeed Dr. James W. Humrichouse.

Dr. Whitridge is one of the leading physicians of Baltimore. He was born in Baltimore, January 26, 1865. In 1886 he graduated from the Johns Hopkins University with the degree of A.B., and in 1888 from the University of Maryland with the degree of M.D. and University Medalist. He served as assistant in gynecology at the Johns Hopkins University from 1889-93; associate in obstetrics, 1893-96; professor of obstetrics, from 1896 to the present time, which chair he still holds; gynecologist, Union Protestant Infirmary, 1895-97. He organized the Obstetrical Department of the Johns Hopkins University and Hospital.

The selection of Dr. Whitridge as president of the faculty is the highest honor that the profession of the State can bestow upon any of its members. The University of Maryland is to be congratulated upon having one of its alumni elected to the position.

At the sessions of the one hundred and seventeenth annual meeting of the Medical and Chirurgical Faculty, which were held in Osler Hall, April 27, 28 and 29, the following members of our alumni read interesting papers or entered into discussions: Drs. J. H. Hartman, T. C. Worthington, E. H. Kloman, John S. Fulton, Robert P. Bay, R. Tunstall Taylor, John R. Winslow, A. J. Underhill, Ernest Zueblin, Albert H. Carroll, R. H. Johnston, George W. Dobbin and Herbert Harlan.

At the election of officers, Dr. Ridgely B. Warfield, class of 1884, was added to the library committee, and Dr. John L. Riley, class of 1905, of Snow Hill, Md., was chosen to fill one of the vacancies on the State Board of Medical Examiners.

A large oil portrait of the late Dr. William Travis Howard, professor of the diseases of women at the University of Maryland from 1867 to 1897, was unveiled in Osler Hall, April 27, as a presentation to the Medical and Chirurgical Faculty of Maryland. The painting, which is a companion piece to the portrait of Dr. L. McLane Tiffany, is by Thomas Corner, and was given to the faculty by Dr. Howard's widow. Dr. J. Whitridge Williams made the presentation speech, and the portrait was accepted on behalf of the faculty by Dr. James W. Humrichouse, the president.

Miss Lucy Hill, University Hospital Training School for Nurses, class of 1914, who was operated on a few days ago at the hospital, is recovering rapidly. The operation was very successful.

Miss Nettie Flanagan, formerly superintendent of nurses of the University Hospital Training School, who has been superintendent of the De Sota Sanatorium, Jacksonville, Fla., for the past three years, has resigned her position and will take up public health nursing in Boston, Mass.

Mrs. Bertie Sigmon, University Hospital Training School for Nurses, class of 1914, who was surgical nurse at the De Sota Sanatorium, Jacksonville, Fla., has resigned her position and has been appointed superintendent of nurses of the Chester Hospital, Chester, S. C.

Drs. James B. Parrymore, Jacksonville, Fla., and Wilmer M. Priest of New York, both of the class of 1909, have been to visit old scenes at the University Hospital lately. While North, Dr. Parrymore "took in" New York. Dr. Priest has been in New York for some time, having been a resident in one of the orthopedic hospitals there.

Other recent visitors to the Hospital were Drs. William Michel of Frostburg, Md., and John D. Darby of Oakley, Md., both of the class of 1912.

Dr. James M. Craighill, class of 1882, surgeon-in-chief of the Baltimore City Police Department, while on a sea trip lately was one of the first to see the German cruiser Kronprintz interned for repairs.

Dr. Elmer H. Adkins, class of 1905, of Roanoke Rapids, N. C., has been visiting the University.

At a meeting last month at Bayview Asylum of the Supervisors of City Charities, the following appointments were made for the ensuing year:

Dr. Everett Le Compte Cook, class of 1914, chief resident physician of the municipal tuberculosis hospital. Dr. Cook has been an intern there for a year.

Dr. Clarence Calvin Hoke, class of 1914, resident physician in the surgical department. Dr. Hoke has also served a year there as an intern.

The following gentlemen were appointed from the senior class:

Surgical Department—Messrs. D. P. Etzler, G. F. Ross and J. J. Waff, B.S.

Tuberculosis Hospital—Messrs. Edgar W. Lane, B.S., and J. A. B. Lowry.

Insane Department—Messrs. Myles B. Sharkey and H. Goldman.

At the annual meeting of the Cecil County Medical Society, held in Elkton, Md., April 22, the following officers were elected:

President—Dr. William D. Carlin, class of [illegible] Elkton.

Vice-President—Dr. Charles L. Miller, Baltimore Medical College, class of 1894, of North East.

Delegate to the State Convention to be held in Baltimore—Dr. H. S. Cantwell, class of [illegible], North East.

Alternate—Dr. J. H. Carring, class of 1876, of Cherry Hill.

We are just in receipt of a postal card from Dr. William Robert Gardiner, class of 1910, who is stationed at Herrin, Ill., in which he says that the world has been treating him beautifully since he left school, and that he is doing a great deal of surgery. He also tells us that he was married to Miss MacWalker of Herrin the 21st of March last. Dr. and Mrs. Gardiner expect to leave for the Fair in San Francisco sometime in May. Dr. Gardiner is connected with the Baker-Gardiner Hospital in Herrin.

Capt. William L. Hart, M.D., U. S. A., class of 1900, is located at Fort Sam Houston, Texas.

On May 18 the State will transfer about 250 insane persons to the new Eastern Shore State Hospital, near Cambridge. Dr. Arthur P. Herring, secretary of the State Lunacy Commission, said that, so far as he knew, such a large number of insane persons had never been moved before. About 150 of the number will come from the Springfield State Hospital for the Insane, at Sykesville; about 60 or 70 from the Spring Grove Hospital for the Insane, at Catonsville, and 23 from the Cecil County Asylum, at Cherry Hill.

The removal of the 23 inmates of the Cecil County Asylum will mark the end of the system of caring for insane in county almshouses—a system that has been sadly inadequate, has led to serious abuses and has been combated by physicians for years. Except in Allegany county, where the county home really is a small hospital, all insane persons are being or will be cared for under the State-aid system, which embraces modern institutions in the several sections of the State.

Unusual arrangements have been made by Dr. Herring to insure safety, both to the insane and the public, in transferring the patients. Those from Springfield will be brought to Baltimore on a special car over the Baltimore & Ohio Railroad, arriving here about 9 o'clock. They will be accompanied by a number of attendants and physicians, and will be met at Camden Station with automobiles and carriages to carry them to the boat and with ambulances for the bedridden. Those from Spring Grove will be brought to the city on the electric cars and the group from Cecil county will come down on the regular early train.

As soon as the groups reach the city they will be taken to the ice-boat Latrobe, at the City Pier, Patapsco river. The boat will have been equipped especially to care for the patients. It really will be a temporary floating hospital, with the open spaces about the railings covered with wire screens to prevent any of the insane getting overboard.

The boat will go directly to the Eastern Shore

Hospital, which is located on the Choptank River, a few miles above Cambridge. There is a wharf on the hospital farm property and the patients will be landed there. It is expected to have them safely lodged in the hospital by mid-afternoon.

The new hospital is one of the best in the State. The commission in charge of the erection of it gathered all the available information as to the best method of arranging the building and equipping it before starting the work, and the location is regarded as one of the best in the State.

Most of the patients to be placed there were residents of the Eastern Shore and it is intended to use the hospital primarily for the Eastern Shore insane, so that their families and friends may easily go to see them.

Dr. Louis Kyle Walker, class of 1911, of Ahoskie, N. C., was also a recent visitor to the University. After graduating Dr. Walker served first as assistant resident pathologist and then as assistant resident gynecologist at the hospital, and as superintendent of the Maryland General Hospital from 1913-1914.

The University of Maryland is issuing a diploma to each of the 2000 members of Baltimore Medical College Alumni Association. The entire membership of the old association is to be included in the membership of the Alumni Association of the University of Maryland, which will bring its total membership up to 5000.

Two years ago the medical college was consolidated with the University of Maryland, thus losing its identity, and graduates of the former institution held diplomas issued by a school which had no existence. It then occurred to the alumni association that perhaps the University of Maryland would be willing to substitute the diplomas held by each alumnus of the medical college for one of its own sheepskins, and the request for such a substitute was laid before the faculty.

As a result of this request a committee consisting of former Judge Henry D. Harlan and Drs. T. O. Heatwole and T. A. Ashby was named to draw up a proper form of diploma which could be presented to the Baltimore Medical College graduates.

Dr. Ashby recently returned from a visit to Georgia and South Carolina, where he went to assist in organizing alumni associations of the University of Maryland. In the near future he will go to North Carolina and West Virginia.

Dr. Nathan R. Gorter, Commissioner of Health, celebrated his 54th birthday on April 26.

Dr. and Mrs. Hiram Woods, who have been spending some time at the Collingmore, in New York, have returned to their residence on Park avenue.

The April meeting of the University of Maryland Medical Society was held in Chemical Hall, northeast corner Lombard and Greene streets, Tuesday, April 13, 1915, at 8.30 P. M. The program, which was most interesting, was as follows:

Eye Hygiene as Applied to Schools (illustrated with lantern pictures), Dr. Hiram Woods.

Some Recent Bronchoscopic and Esophageal Cases (illustrated), Dr. Richard H. Johnston.

Fractional Gastric Analysis in Gall-stone Cases (a brief report), Dr. Albert H. Carroll.

MARRIAGES

Dr. Edwin Baker Goodall, class of 1909, of Haverhill, Mass., to Miss Carrie Hollander of Amesburg, Mass., at Amesburg, April 29, 1915.

Dr. Ernest William Frey, class of 1912, to Miss Mary Jeanette Disney, both of Baltimore, Md., at Baltimore, March 22, 1915.

Dr. William Robert Gardiner, class of 1910, to Miss MacWalker, both of Herrin, Ill., at Herrin, March 21, 1915. They will reside in Herrin, where Dr. Gardiner is practicing surgery.

DEATHS

Dr. Marshall Langton Price, class of 1902; in 1910 secretary and in 1911 vice-chairman of the Section on Preventive Medicine and Public Health of the American Medical Association; a member of the American Public Health Association, medical officer of the Tuberculosis Commission of Maryland from 1903 to 1905; secretary of the Maryland State Board of Health from 1907 to 1913; member of the Maryland-District of Columbia Sewerage Commission in 1912; originator of the first law for the State control of tuberculosis, now in effect in many States of the Union and known as the "Maryland System,"

who moved from Baltimore in 1914 on account of ill-health to Boise, Idaho, died at sea on board of the American Line Steamer St. Paul, April 16, 1915, presumably from tuberculosis, and was buried at sea the next day, aged 37 years.

In his brief career Dr. Price had done [illegible] brilliant work as a sanitarian and was well known for his efforts in behalf of public-health measures. He was the author of several laws regulating the public health, including the statute in this State for the State control of tuberculosis, which has been widely copied and is called the "Maryland System."

Dr. Price was born in California April 28, 1878, the son of Maj. Curtis Ethelbert Price, U. S. A. He graduated at the University of Maryland Medical School in 1902 and was resident physician at the University Hospital for two years. He then became secretary to the Tuberculosis Commission of Maryland, and later medical assistant to the State Board of Health, and on May 1, 1907, was elected secretary of the board, which position he held six years. At the expiration of that time he went West.

Dr. Charles Ellis Ross, class of 1889, a Fellow of the American Medical Association, for [illegible] years a member of the medical staff of the Morganton (N. C.) State Hospital and member of the Board of Health of Burke county, died in Grace Hospital, Morganton, April 1, 1915, from pneumonia, aged 52 years.

Dr. William B. Smith, class of 1899, a Fellow of the American Medical Association and a practitioner of Hampton, Va., who sailed for Bristol, England, February 25 as surgeon of the steamer Victoria, died in Bristol, March 10, 1915, aged [illegible] years.

Dr. [illegible] Blair, [illegible] class of 1912, of Greenville, S. C., died at Mobile, Ala., while on [illegible], March 6, 1915, aged 26 years.

Dr. [illegible] Cole, class of 1858, a practicing physician of Catonsville, Md., until 1893, died at his home in Mt. Airy, Md., March 14, 1915, from cerebral hemorrhage, aged 59 years.

Dr. Horace M. Julian, class of 1885, died at his home in [illegible], January 30, 1915, from cerebral hemorrhage, aged 71 years.

Dr. R. Sydney Cauthen, Baltimore Medical College, class of 1902, a Fellow of the American Medical Association, a specialist on diseases of the eye, ear, nose and throat, of Charlotte, N. C., died at his home in Charlotte, March 24, 1915, from heart disease, aged 43 years.

Dr. Charles Ellsworth Boyd, Baltimore Medical College, class of 1902; University of Wooster, Cleveland, 1892; a Fellow of the American Medical Association, died at his home in Newton, Iowa, February 27, 1915, from pneumonia, aged 45 years.

Dr. Edward G. Altvater, class of 1911, of 323 N. Carrollton avenue, a physician at the United States Quarantine, died May 2, 1915, at the University Hospital, following an operation, aged 30 years.

Dr. Altvater was born in Baltimore, the son of the late Garrett Altvater. His grandfather was the late Dr. Garrett Altvater, who was at one time physician at the Quarantine Station and at the city jail. His uncle was the late Dr. Edward Altvater of Upper Falls, Md.

Beginning his education at the public schools, Dr. Altvater later attended Deichmann's Preparatory School. In 1911 he was graduated from the University of Maryland and took up his duties as intern at the Spring Grove State Hospital, Catonsville, where he spent a number of years. He was a member of the Masons, Odd Fellows, Junior Order of American Mechanics and the Press Club. He is survived by his mother, Mrs. Mary G. Altvater; a brother, Alpha M. Altvater, and two sisters, Mrs. Peter Tribels and Mrs. Laurens B. Pendleton, Washington.

Dr. William Joseph Dougherty, Baltimore Medical College, class of 1907, of Beverly Farms, Mass., died at the home of his mother in that place, April 6, 1915, aged 33 years.

Dr. J. H. Turner, class of 1840, of Martinsville, Va., died at the home, April 1, 1915, from senile debility, aged 80 years.

Dr. James Bell Claude, class of 1868, of Forest Glen, Md., died at his home, April 7, 1915, aged 71 years.

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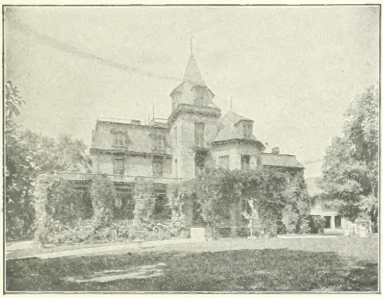

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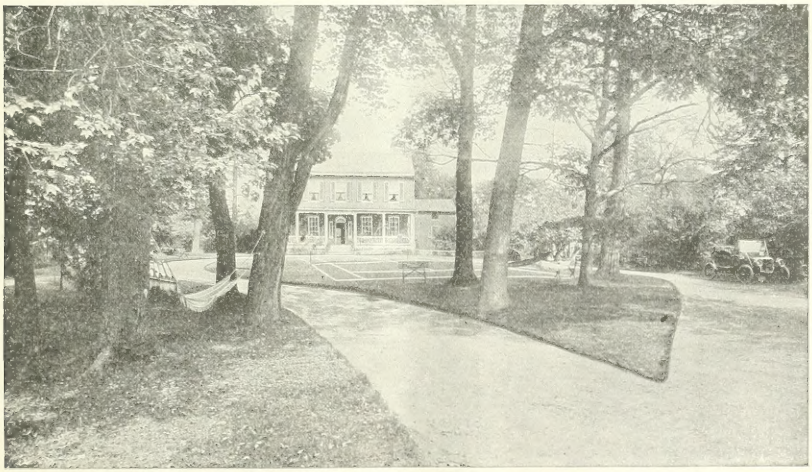

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